

Policy Number: _____

Policyholder: _____

1. PLEASE FULLY COMPLETE THIS FORM
2. ATTACH ITEMIZED BILLS
3. MAIL TO HSR

Insurance coverage is underwritten by Berkley Life and Health Insurance Company, (domiciled in Iowa - California Certificate of Authority #08527) or StarNet Insurance Company (domiciled in Iowa - California Certificate of Authority #6978)

Health Special Risk herein referred to as the "Administrator."

**ACCIDENT AND SICKNESS CLAIM FORM
PART I – POLICYHOLDER’S REPORT**

1. Claimant’s Name (Injured Person)	2. Gender <input type="checkbox"/> M <input type="checkbox"/> F	3. Date of Birth	4. E-Mail
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5. The Injured Person’s Social Security Number

Please note that the Injured Person’s Social Security Number MUST be provided as required by the Center for Medicare Services.

6. Address of Injured Person and Best Contact Phone Number (Include Area Code)

7. If Applicable, Parent’s Name, Address, and Best Contact Phone Number (Include Area Code)

8. Date and Time of Accident or Date Sickness Began	9. Nature of Injury or Sickness (indicate part of body injured – such as broken, arm, sprained ankle, etc.)	10. The injured person was a: <input type="checkbox"/> Participant <input type="checkbox"/> Staff Member <input type="checkbox"/> Guest <input type="checkbox"/> Volunteer
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Dental Claims	11. Indicate which Teeth were Involved in the Accident	12. Describe Condition of Injured Teeth Prior to Accident: <input type="checkbox"/> Whole, Sound, and Natural <input type="checkbox"/> Filled <input type="checkbox"/> Capped <input type="checkbox"/> Artificial
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13. Type of Injury (Indicate Part of Body Injured – e.g. broken arm, sprained ankle, etc.) **Did Injury Result in Death?**
 YES NO

14. Describe How Accident Occurred – Give All Possible Details **Did Injury Result in Death?** YES NO

15. Did Accident Occur (Check Yes or No for Each of the Following):

- | | | |
|--|------------------------------|-----------------------------|
| A. During a policyholder programmed, sponsored & supervised, or sanctioned activity? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| B. On activity premises? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| C. While on the job (if applicable)? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| D. While traveling directly and uninterruptedly to or from home and policyholder premises? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| E. During intercollegiate/scholastic athletic practice? <input type="checkbox"/> YES <input type="checkbox"/> NO or competition? | | |

16. Name of Event or Activity	17. Name and Title of Supervisor
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18. Name of Policyholder

19. Signature of Policyholder Representative	20. Title of Policyholder Representative	21. Date
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PART II – OTHER INSURANCE STATEMENT

Do you/spouse/parent have medical/health care or is the Claimant enrolled as an individual, employee or dependent member of a Health Maintenance Organization (HMO) or similar prepaid health care plan, or any other type of accident/health/sickness plan coverage through your employer or other source on you or does your son/daughter have health care coverage as a dependent from your previous marriage as mandated in a divorce decree? YES NO

If Yes, name of insurance company _____

Policy# _____

Name of insurance company _____

Policy# _____

Claimant's primary employer name, address, and phone number _____

Mother's primary employer name, address, and phone number _____

Father's primary employer name, address, and phone number _____

IF OTHER INSURANCE OR HEALTH CARE PLANS EXIST, PLEASE SUBMIT COPIES OF THEIR EXPLANATION OF BENEFITS along with your claim.

IF NOT OTHER INSURANCE or HEALTH PLAN EXISTS, PLEASE READ & SIGN BELOW.

I agree that should it be determined at a later date there is insurance (or similar), to reimburse HEALTH SPECIAL RISK, INC., or the insurance company to the extent of any amount collectible.

SIGNATURE OF PARTICIPANT OR PARENT _____

DATE _____

PART III – AUTHORIZATION TO PAY BENEFITS TO PROVIDER

AUTHORIZATION TO PAY BENEFITS TO PROVIDER: I hereby authorize medical payments to be made directly to doctor(s), hospital(s), or indicated provider(s) of service(s) in connection with this claim. (If not signed submit proof of payment)

CLAIMANT OR AUTHORIZED REPRESENTATIVE SIGNATURE _____

DATE _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION:

I hereby authorize any licensed physician; medical practitioner; hospital; clinic or other medical facility; insurance company; employer; Medical Information Bureau; Motor Vehicle Administration or other organization; or persons that have any records or knowledge of me or my physical or mental health condition to give Berkley Life and Health Insurance Company, StarNet Insurance Company (Berkley), its authorized Administrator or their legal representative, and any agent acting on their behalf any such information. I also authorize Berkley or its authorized Administrators or their legal representatives, to release medical and billing information to any family member or health care provider if necessary to facilitate any potential payments.

I understand that this information will be used to determine my eligibility for coverage and that I may revoke this authorization at any time by providing written notice to Berkley or its authorized Administrator. I understand that I may revoke this authorization except to the extent that action has already been taken based upon this authorization. The revocation may not take effect before the date received by Berkley Group Company or its authorized Administrator.

A photocopy of this authorization shall be as valid as the original. This authorization shall be valid for 24 months from the date below (In AZ, CA, CT, GA, HI, IL, ME, MA, MN, NV, NC, NJ, NM, OH, and VA authorization shall be valid during the duration of the claim. In WI, authorization is valid during the duration of the claim or 24 months, whichever is longer). I acknowledge that I, or my authorized representative, am entitled to receive a copy of this authorization upon request.

I understand that the authorized Administrator may condition payment of a claim upon my signing this authorization, if the disclosure of information is necessary to determine the level or validity of the claim payment. I also understand, once information is disclosed pursuant to this Authorization, the information will remain protected by the authorized Administrator in accordance with federal or state law.

DECLARATION: These statements are true and complete to the best of my knowledge.

Warning: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **FOR**

RESIDENTS OF NEW YORK: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. (Fraud language varies by state. Please see below.)

Printed Name of Claimant or Authorized Representative _____ Relationship _____

Signature of Claimant or Authorized Person _____ Date _____

By entering your name above in Part II and Part III, you are signing this claim form electronically. You agree your electronic signature is the legal equivalent of your manual/handwritten signature on this claim form.

***Attention California Residents** - please refer to following link for an important notice regarding the collection of Personal Information. <https://www.berkeley.com/privacy#californiaCollectionAtNotice>

FRAUD WARNING

FOR RESIDENTS OF ALASKA: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

FOR RESIDENTS OF ARIZONA: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

FOR RESIDENTS OF CALIFORNIA: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

FOR RESIDENTS OF COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

FOR RESIDENTS OF DELAWARE AND IDAHO: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information is guilty of a felony.

FOR RESIDENTS OF FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

FOR RESIDENTS OF INDIANA: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

FOR RESIDENTS OF KANSAS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of insurance fraud as determined by a court of law and may be subject to fines and confinement in prison.

FOR RESIDENTS OF KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

FOR RESIDENTS OF MARYLAND: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

FOR RESIDENTS OF MAINE, TENNESSEE, VIRGINIA AND WASHINGTON: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

FOR RESIDENTS OF MINNESOTA: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

FOR RESIDENTS OF NEW HAMPSHIRE: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

FOR RESIDENTS OF NEW JERSEY: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

FOR RESIDENTS OF NEW MEXICO: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

FOR RESIDENTS OF NEW YORK: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

FOR RESIDENTS OF OHIO AND OKLAHOMA: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

FOR RESIDENTS OF OREGON: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

FOR RESIDENTS OF PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

FOR RESIDENTS OF PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

FOR RESIDENTS OF VERMONT: Any person who knowingly presents a false statement in a claim for proceeds of an insurance policy may be guilty of a criminal offense and subject to penalties under state law.

HOW TO FILE A CLAIM

Listed below are important instructions and comments about filing a claim.

YOUR CLAIM FORM

1. This claim form should be fully completed and submitted within 90 days from the date of injury. Be sure to answer and complete the section regarding “**OTHER INSURANCE STATEMENT**”, marking either yes or no, and signing the line for authorization, so that **HSR** and the doctors/hospital may communicate concerning your claim.
Incomplete claim forms are one of the most frequent reasons why claim payments are delayed.
2. Only one claim form for each accident or sickness needs to be submitted.
3. Once completed, make a photocopy for your records, and mail to the address shown below.
4. DO NOT assume that anyone else will mail this claim form to **HSR** for you.

YOUR BILLS

1. Please advise all doctors/hospitals regarding this coverage so they may forward us their itemized bills.
2. If you have already been to the doctor/hospital and did not know about this coverage, then please send all the itemized bills to **HSR** at the address shown below.
3. **The bills should include the name of the doctor/hospital, their complete mailing address, telephone number, the date you were seen by the doctor/hospital, what the doctor saw you for (diagnosis) and the specific itemized charges incurred.**
4. If this information is not on the bill when you send this in we will have to contact the doctor/hospital which will delay the review of your claim. “Balance Due” statements do not contain sufficient information to complete your claim..

MMSEA

Federal mandate in Section 111, MMSEA requires **HSR** to obtain specific information prior to processing any medical claims. You may view this mandate at <https://www.cms.gov/files/document/mmsea-111-mbi-ssn-collection-nghp-model-language.pdf> Below is a list of the required information.

- Last Five Digits of the Social security number, If the claimant is a minor we require the social security number of the minor, not the parent.
- Date of birth
- Gender

If you have any questions, please contact Customer Service at (866) 523-3269. They are available from 8:00 a.m. thru 6:00 p.m. Central time, Monday – Friday. You may also forward any documents by fax to (972) 512-5820.

Health Special Risk, Inc.
8400 Belleview Drive, Suite 150
Plano, Texas 75024